BH Couples Intake / Diagnostic Assessment Interview Guide

Date _____

Client Identifying Information:

Client 1	Client 2
Client's initials _____ MRN _____	Client's initials _____ MRN _____

Referral Source:

Presenting Couples/Relationship Concerns:

Presenting individual concerns for Client 1 (if indicated)	Presenting individual concerns for Client 2 (if indicated)

Client Goals for Treatment:

Client 1	Client 2

Preferences for Treatment/Services:

Individual treatment/services Client 1 (if indicated)	Individual treatment/services Client 2 (if indicated)

	Client 1		Client 2	
Behavioral Health History	**Yes**	**No**	**Yes**	**No**
1. Have you ever had behavioral health treatment before?				
2. Have you ever had couples/relationship treatment before (past or current relationship)?				
3. Have you ever had any psychiatric hospitalizations before?				
4. Do you have concerns about behaviors that at times feel out of control to you (e.g. sex, food, gambling, substances, spending, etc.)				
5. Have you ever felt that someone else can control your thoughts?				
6. Have you ever heard or seen things that that nobody else can hear or see?				
7. Have you ever engaged in self-injury or intentionally hurt yourself?				
8. Do you currently have suicidal feelings?				
9. Have you had suicidal feelings in the past?				
10. Have you ever attempted suicide?				
11. Do you currently have feelings of killing or hurting others?				

Comments:

	Client 1		Client 2	
Substance Use/Addictive Behavior History	**Yes**	**No**	**Yes**	**No**
1. Do you have a history of or current substance use or other addictive behaviors?				
2. Do you have any history of physical or medical problems associated with substance use?				
3. Has substance use caused any problems in any areas of your life?				
4. Have substance use and/or addictive behaviors ever caused problems within your family unit?				
5. Have you ever had an overdose?				
6. Have you ever witnessed an overdose?				

Substance Use/Addictive Behavior Treatment History:

Client 1	Client 2

Substance Use/Addictive Behavior Assessment:

Client 1	Client 2
Client enrolled in SATP ☐	Client enrolled in SATP ☐

	Client 1		Client 2	
Trauma/Violence Exposure History	**Yes**	**No**	**Yes**	**No**
1. Have you ever experienced physical, sexual, or emotional abuse?				
2. Have you ever been physically or verbally assaulted because of any aspect of your identity or appearance?				
3. Have you ever witnessed violence?				
4. Have you ever worried that you might have abused another person?				
5. In the last year, have you felt isolated, trapped, or like you are walking on eggshells in an intimate relationship?				
6. In the last year, has your partner controlled where you go, who you talk to, or how you spend money?				
7. In the past year, have you been forced, or felt pressured to do something sexual that you didn't want to do?				
8. In the last year, has someone hit, kicked, punched, or otherwise hurt you?				
9. In the past year, have you been forced, or felt pressured to do something in exchange for food, housing, transportation, or other needs?				
Comments:				

	Client 1		Client 2	
Medical Concerns	**Yes**	**No**	**Yes**	**No**
1. Do you have any health or medical issues or concerns that impact your emotional wellbeing?				
2. Do you experience chronic pain?				
3. Do you have any questions or concerns about your risk for infection with HIV, STD's, and hepatitis?				
4. Do you have any questions / concerns related to current / past pregnancies?				
5. Do you have any question / concerns related to your reproductive health?				

Client 1	Client 2
6. Date of Last Physical Exam *(include month and year if known)*: _____ If Last Physical Exam Greater than 1 year ago *(check one)*: ____ Patient agrees to make appointment for physical exam ____ Patient agrees to set goal of making appointment for physical exam	6. Date of Last Physical Exam *(include month and year if known)*: _____ If Last Physical Exam Greater than 1 year ago *(check one)*: ____ Patient agrees to make appointment for physical exam ____ Patient agrees to set goal of making appointment for physical exam

Comments:

	Client 1		Client 2	
Nutrition / Eating Concerns	**Yes**	**No**	**Yes**	**No**
1. Do you have any concerns about your eating practices, including food allergies or problems following a special diet?				
2. Do you have dental problems that make it difficult to eat?				
3. Have you ever binged, purged or restricted your food intake?				
4. Do you make yourself sick because you feel uncomfortably full?				
5. Do you worry that you have lost control over how much you eat?				
6. Have you recently lost more than 14 pounds in a three month period?				
7. Do you have any concerns regarding your body image and/or weight?				
8. Would you say that food dominates your life?				

Comments:

	Client 1		Client 2	
Sexual Orientation / Sexual Functioning Questions and Concerns	**Yes**	**No**	**Yes**	**No**
1. Do you or your partner have any questions or concerns about your sexual orientation?				
2. Do you or your partner have any sexual functioning concerns?				
Comments:				

	Client 1		Client 2	
Gender Identity Questions and Concerns	**Yes**	**No**	**Yes**	**No**
1. Do you or your partner have any questions or concerns about your own gender or gender identity?				
Comments:				

Social Support/Family/Relationship History

Client 1	Client 2
1. What is your relationship status? (Check all that apply) ____ Single ____ Legally Married ____ Widowed ____ Partnered (not living together) ____ Living with Partner/Spouse ____ Divorced ____ Separated	1. What is your relationship status? (Check all that apply) ____ Single ____ Legally Married ____ Widowed ____ Partnered (not living together) ____ Living with Partner/Spouse ____ Divorced ____ Separated

Social Support/Family/Relationship History (CONT'D)

Client 1	Client 2
2. Relationship History:	2. Relationship History:

	Client 1		Client 2	
Social Support/Family/Relationship History (CONT'D)	**Yes**	**No**	**Yes**	**No**
3. Do you feel that you have adequate social supports in your life?				
4. Have you had prior primary relationships?				
5. Do you have children?				
6. Are you the primary caretaker / guardian for any children, elders, pets, or other dependents?				
7. Are any of the relationships in your life a source of stress or conflict?				
8. Is spirituality or religion important in your life?				

9. Activities that bring shared enjoyment and enhance your relationship: (Please list)

Client 1	Client 2
10. Other important hobbies, interests, recreational activities, additional social supports? (Please list)	10. Other important hobbies, interests, recreational activities, additional social supports? (Please list)

Comments:

	Client 1		Client 2	
Is there a family history of…	**Yes**	**No**	**Yes**	**No**
1. Alcohol or drug abuse?				
2. Mental illness?				
3. Domestic violence?				
4. Estrangement/significant conflict?				

Comments:

	Client 1		Client 2	
Employment/Financial Concerns	**Yes**	**No**	**Yes**	**No**
1. Are you currently employed?				
2. Partner(s) currently employed?				
3. Is work a significant source of stress for you?				
4. Is maintaining employment a problem for you?				

Client 1	Client 2
5. What is your source of income? (Check all that apply) ____ None ____ AFDC ____ General Relief (EAEDC) ____ SSI/SSDI ____ Unemployment ____ Veteran's Benefits ____ Worker's Comp ____ Wages ____ Investment/Trust ____ Other	5. What is your source of income? (Check all that apply) ____ None ____ AFDC ____ General Relief (EAEDC) ____ SSI/SSDI ____ Unemployment ____ Veteran's Benefits ____ Worker's Comp ____ Wages ____ Investment/Trust ____ Other
6. What best describes your current financial situation? (Check all that apply) ____ Comfortable/living within means ____ Occasional struggle with finances ____ Often struggles with finances ____ Financial struggles are a major source of stress	6. What best describes your current financial situation? (Check all that apply) ____ Comfortable/living within means ____ Occasional struggle with finances ____ Often struggles with finances ____ Financial struggles are a major source of stress
Comments:	

	Client 1		Client 2	
Employment/Financial Concerns (CONT'D)	**Yes**	**No**	**Yes**	**No**
7. Do you have a legal guardian or rep payee?				
8. Did you ever serve on active duty in the Armed Forces?				

Comments:

	Client 1		Client 2	
Housing Concerns	**Yes**	**No**	**Yes**	**No**
1. Are you satisfied with your current living situation?				
2. Are you at risk of losing your housing?				
Comments:				

	Client 1		Client 2	
Legal Concerns	**Yes**	**No**	**Yes**	**No**
1. Have you ever had to obtain protection order for yourself (i.e. restraining order, harassment order)?				
2. Have you ever been charged with a criminal offense or been involved with any legal proceedings?				
Current and past legal involvement, DUIs, probation, name of probation contact, court documentation needs:				

Client 1

Mental Status/Risk Assessment

Appearance:	Motor Activity:	Thought Content:
____ Appropriate Dress	____ Normal Movements	____ Normal
____ Bizarre Dress	____ Increase motor activity (restless/agitated physically)	____ Delusional
____ Disheveled	____ Slowed motor activity	____ Paranoid
____ Poor hygiene	____ Unusual motor activity (tics/tremors/spastic)	____ Tangential
		____ Psychotic blocking/word salad/bizarre
Speech:	**Affect:**	**Mood:**
____ Normal rate/rhythm	____ Constricted	____ Normal
____ Pressured	____ Normal	____ Depressed
____ Slowed	____ Depressed	____ Euphoric
	____ Excited	____ Anxious
	____ Blunted/flat/absent	____ Irritable
Comments:		

Current Suicidality		Past Suicidality	
____ None	____ Ideation	____ None	____ Ideation
____ Intent	____ Plan	____ Intent	____ Plan
Current Homicidality		**Past Homicidality**	
____ None	____ Ideation	____ None	____ Ideation
____ Intent	____ Plan	____ Intent	____ Plan

Current Overdose Risk Potential

____ N/A

____ None – *no risk or good awareness of risk and prevention methods*

____ Low – *minimal risk of overdose and some degree of awareness of risk and prevention methods, intermittent opiate use*

____ Moderate – *some difficulty understanding overdose risk and prevention methods, active IV opiate use*

____ High – *little ability to understand overdose risk, little awareness of possible threat when using IV heroin, uses no prevention methods, prior overdose, active IV opiate use*

____ Severe – *unaware of overdose risk, high daily use, presence of serious co-occurring disorder, being newly sober following detox, prior overdose, active IV opiate use*

Client 2

Mental Status/Risk Assessment

Appearance:	Motor Activity:	Thought Content:
____ Appropriate Dress	____ Normal Movements	____ Normal
____ Bizarre Dress	____ Increase motor activity (restless/agitated physically)	____ Delusional
____ Disheveled	____ Slowed motor activity	____ Paranoid
____ Poor hygiene	____ Unusual motor activity (tics/tremors/spastic)	____ Tangential
		____ Psychotic blocking/word salad/bizarre
Speech:	**Affect:**	**Mood:**
____ Normal rate/rhythm	____ Constricted	____ Normal
____ Pressured	____ Normal	____ Depressed
____ Slowed	____ Depressed	____ Euphoric
	____ Excited	____ Anxious
	____ Blunted/flat/absent	____ Irritable
Comments:		

Current Suicidality		Past Suicidality	
____ None	____ Ideation	____ None	____ Ideation
____ Intent	____ Plan	____ Intent	____ Plan
Current Homicidality		**Past Homicidality**	
____ None	____ Ideation	____ None	____ Ideation
____ Intent	____ Plan	____ Intent	____ Plan

Current Overdose Risk Potential

____ N/A

____ None – *no risk or good awareness of risk and prevention methods*

____ Low – *minimal risk of overdose and some degree of awareness of risk and prevention methods, intermittent opiate use*

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____ Severe – *unaware of overdose risk, high daily use, presence of serious co-occurring disorder, being newly sober following detox, prior overdose, active IV opiate use*

Observation of couple/relationship unit interaction (eye contact, physical interaction, communication patterns):

Assessment of risk (including past and present suicidal/homicidal ideation and attempts, assaultive and self-injurious behavior, protective factors):

Client 1	Client 2

Protective factors: (Include as part of risk assessment in CPS form)

Client 1	Client 2

Diagnoses:

Client 1	Client 2

Psychosocial and Contextual Factors:

Client 1	Client 2

Diagnostic Impressions/Formulation of Couple/Relationship Unit:

Diagnostic Impression Formulation specific to Client 1	Diagnostic Impression Formulation specific to Client 2

Treatment Recommendations/Plan for Couple/Relationship Unit:

If applicable, Additional Tx Recommendation for Client 1	If applicable, Additional Tx Recommendation for Client 2